

STATE OF NEBRASKA
DEPARTMENT OF HEALTH AND HUMAN SERVICES REGULATION AND LICENSURE
CREDENTIALING DIVISION
P.O. BOX 94986
LINCOLN, NE 68509-4986
800-422-3460 / 402-471-2158

**EMERGENCY MEDICAL SERVICES
VERIFICATION OF TRAINING AND CERTIFICATION/LICENSURE**

STATE OR JURISDICTION: _____

Our records certify that (Name) _____ was granted
License/Certificate No. _____ to practice as a:

☐ First Responder

☐ Emergency Medical Technician

☐ Emergency Medical Technician – Intermediate

☐ Emergency Medical Technician – Paramedic

Issuance Date: _____

Social Security No. _____

Expiration Date: _____

Date of Birth: _____

This licensure/certification was issued based on:

☐ Reciprocity with _____

☐ Completion of a United States Department of Transportation, National Highway Traffic Safety
Administration, National Standard Curriculum,

(Name of Curriculum)

☐ Other Training: Please specify _____

Did the aforementioned individual pass an examination? ☐ Yes ☐ No

Name of the examination: _____

Scores the individual received: _____ Written _____ Practical

Has the applicant's certification/license ever been:

Suspended: ☐ Yes ☐ No

Revoked: ☐ Yes ☐ No

Other disciplinary action: ☐ Yes ☐ No

If yes to any of the above, please explain:

Date: _____

Name and Title: _____

Licensing Agency: _____

Address: _____

City/State/Zip: _____

SEAL

Signature: _____

HHSS/R&L
3/22/99